Specialized Medical Equipment and Supplies and Assistive Technology Protocol Checklist

Service Recipient's Name _____ **Date of Birth** _____
(Last, First)

Reviewer's Name _____ **Date Request Submitted** _____
(Last, First)

Technical Review

☐ **YES** ☐ **NO**	Is the correct funding source, site code, and service code used in Section C of the Individual Support Plan? If **YES**, continue to Question #1. If **NO** and the wrong funding source, site code and service code is due to a simple error, correct the error and continue to Question #1. If **NO** based on lack of a site code because the provider is not licensed or does not have an approved provider agreement, deny as non-covered due to failure to meet provider qualifications as specified in the waivers and in the TennCare rules applicable to the waivers.

A. Criteria for Specialized Medical Equipment and Supplies and Assistive Technology

1. ☐ **YES** ☐ **NO**	Is the requested item one of the following specific exclusions in the waiver service definition: (A. 1) a. An item that is not of direct medical or remedial benefit to the enrollee; **OR** (A. 1. a) b. Prescription and over-the-counter medications; **OR** (A. 1. b) c. Swimming pools, hot tubs, and health club memberships; **OR** (A. 1. c) d. Elevators, stairway lifts, and lift chairs; **OR** (A. 1. d) e. Carpets, floor pads and mats; **OR** (A. 1. e) f. Recreational or exercise equipment; **OR** (A. 1. f) g. Toys; **OR** (A. 1. g) h. Furniture, lamps, and lighting; **OR** (A. 1. h) i. Beds, mattresses, and bedding; **OR** (A. 1. i) j. Diapers and other incontinence supplies; **OR** (A. 1. j) k. Food and food supplements; **OR** (A. 1. k) l. Water purifiers and humidifiers; **OR** (A. 1. l)

	m. Sensory processing/sensory integration equipment or other items (e.g., ankle weights, weighted vests or blankets, therapy balls, swings, vibrators, floor mats, balance boards, brushes); **OR** (A. 1. m) n. Supplies other than those specifically required for the proper functioning of specialized medical equipment or assistive technology within the scope of this definition; **OR** (A. 1. n) o. Physical modification of the interior or exterior of a place of residence; **OR** (A. 1. o) p. Physical modification of a motor vehicle? (A. 1. p) If **YES**, stop and deny as a **non-covered service** based on the waiver service definition. *In addition,* deny as a **non-covered service** any portion of the requested amount of Specialized medical Equipment, Supplies & Assistive Technology which *exceeds* the waiver service limit of $10,000 per service recipient per two (2)-program year period. If **NO**, proceed to Question #2.
2. ☐ **YES** ☐ **NO**	Is the requested item one of the following: (A. 2) a. An assistive device or adaptive aid or control designed for individuals with special functional needs which: (A. 2. a) (1) Increases the ability to perform activities of daily living, including but not limited to: (a) Adaptive eating utensils and dishware (e.g., dishes, glasses, cups, forks, spoons) for individuals with special needs; **OR** (A. 2. a(1)(a)) (b) An adaptive toothbrush; **OR** (A. 2. a(1)(b)) (2) Increases the ability to communicate with others, including but not limited to: (a) A hearing aid; **OR** (A. 2. a(2)(a)) (b) An alternative augmentative communication device or system; **OR** (A. 2. a(2)(b)) (c) An adaptive phone for an individual with visual or hearing impairments; **OR** (A. 2. a(2)(c)) (3) Increases the ability to perceive or control the environment within the home (e.g., a smoke alarm with a vibrating pad or flashing light); **OR** (A. 2. a(3)(a)) b. A stander or standing table; **OR** A. 2. a(3)(b)) c. A gait trainer; **OR** A. 2. a(3)(c)) d. A sidelyer or similar positioning device; positioning wedges, positioning rolls, or similar positioning items; **OR** A. 2.a(3)(d)) e. Supplies necessary for the proper functioning of specialized medical

	equipment or assistive technology covered under the waiver definition; **OR** A. 2. a(3)(e)) f. Repair of specialized medical equipment or assistive technology devices covered under the waiver definition when the repair is not covered by warranty and when it is substantially less expensive to repair the equipment or device than replace it? A. 2. a(3)(f)) If **YES**, proceed to Question #3. If **NO**, stop and deny as a **non-covered service** based on the waiver service definition. *In addition,* deny as a **non-covered service** any portion of the requested amount of Specialized Medical Equipment, Supplies & Assistive Technology which exceeds the waiver service limit of $10,000 per service recipient per two (2)-program year period.
3. ☐ **YES** ☐ **NO**	Is the service recipient age 21 years or older? (A. 3.) If **YES**, skip to Question #5. If **NO**, proceed to Question #4.
4. ☐ **YES** ☐ **NO**	Is the requested item one of the following: (A. 4.) a. Hearing aid; **OR** (A. 4. a.) b. Alternative Augmentative Communication System; **OR** (A. 4. b.) c. A stander or standing table; **OR** (A. 4. c.) d. A gait trainer; **OR** (A. 4. d.) e. A sidelyer or similar positioning device; positioning wedges, positioning rolls, or similar positioning items? (A. 4. e.) If **YES**, stop and deny based on the waiver being the **payor of last resort**. If **NO**, skip to Question #7.
5. ☐ **YES** ☐ **NO**	Is the requested item one of the following: (A. 5.) a. A gait trainer; **OR** (A. 5. a.) b. A sidelyer or similar positioning device; positioning wedges, positioning rolls, or similar positioning items? (A. 5. b.) If **YES**, proceed to Question #6. If **NO**, skip to Question #7.
6. ☐ **YES** ☐ **NO**	Was a request for the specialized medical equipment or assistive technology (or related supplies) denied through the TennCare MCO fair hearing process and, if applicable, denied or not covered by Medicare? (A. 6.) If **YES**, proceed to Question #7. If **NO**, stop and deny based on the waiver being the **payor of last resort**. Include the following statement in the denial letter: "This item may be covered by TennCare, if

	medically necessary. Federal law says that we can't pay for care under the waiver that is covered under the TennCare Program."
7.	Medical necessity review questions**:** (A. 7.)
a. ☐ **YES** ☐ **NO**	a. Is there sufficient information in the Individual Support Plan (ISP) and supporting documentation to show that the service recipient has functional limitations for which specialized medical equipment or assistive technology (or supplies for the proper functioning of such equipment) is needed to enable the enrollee to better perform activities of daily living or to perceive, control, or communicate with the environment; **AND** (A. 7. a.)
b. ☐ **YES** ☐ **NO**	b. Is there documentation that the requested specialized medical equipment or assistive technology (or related supplies, if applicable) has been recommended by a qualified health care professional (e.g., physician, occupational therapist, physical therapist) based on an assessment of the service recipient's functional limitations and capabilities involving activities of daily living; **AND** (A. 7. b.)
c. ☐ **YES** ☐ **NO**	c. Is there sufficient information in the ISP and/or supporting documentation to show that the specialized medical equipment or assistive technology (or related supplies, if applicable) would be of direct medical or remedial benefit to the service recipient; **AND** (A. 7. c.)
d. ☐ **YES** ☐ **NO**	d. Is there documentation that the requested specialized medical equipment or assistive technology (or related supplies, if applicable) is the least costly alternative that is adequate to meet the needs of the service recipient? (A. 7. d.)
	If **YES *to all four*** criteria specified in "7.a" through "7.d" above, stop and approve the covered item (subject to the waiver service limit of $10,000 per service recipient per two (2)-program year period).
	If **NO to any** criterion specified in "7.a" through "7.d" above, stop and deny as **not medically necessary**. All of the unmet medical necessity criteria must be specified in the denial letter.
	In addition, deny as a **non-covered service** any portion of the requested amount of Specialized Medical Equipment, Supplies & Assistive Technology which *exceeds* the waiver service limit of $10,000 per service recipient per two (2)-program year period.
☐ **Approved**	
☐ **Denied**	Criteria_____ not met.